



AZ Medicaid Technical Consortium Meeting

April 1, 2004

2:30 PM to 4:00 PM

AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:

(Based on sign-in sheets)

ADHS/BHS

Thomas Browning

Lee Cisney

Brian Heise

CJ Major

AHCCCS

Deborah Burrell

Melonie Carnegie

Michelle Dillon

Chris Herrick

Sara Harper

Ester Hunt

Dan Lippert

Dennis Koch

MaryKay McDaniel

Brent Ratterree

Marna Richmond

Lydia Ruiz

Carrie Stamos

Linda Stubblefield

Mike Upchurch

Nancy Upchurch

AmeriChoice

Ramkumar Manakal

APIPA

Lucy Markov

Charles Revenew

Sean Stepp

Sharon Zamora

Care 1st Arizona

Bill Hobbs

Herb Woo

DES

Marcella Gonzalez

Major Williams

Nicole Yarborough

Evercare Select

Vicki Johnson

Healthchoice AZ

Paul Benson

Ethan Schweppe

Mike Uchrin

HCSO

Michael Wells

IHS

Charolett Melcher

MCP & Schaller Anderson

Cathy Jackson

Ann Romer

Art Schenkman

Maricopa

Dave Abraham

PHP

Mike Flynn

JoAnn Ward

UFC

Eric Nichols

Kathleen Oestreich

Kathy Steiner

United Drugs

Rand Skelton

Yavapai County

Dave Soderberg

1. Welcome (Lori Petre)

We will go ahead and get started. We do have a shortened meeting timeframe today. We have provided you with a copy of the minutes from the last meeting. Sara Harper is here today to give us an update on the FFS Physicians Fee Schedule and the Outpatient Hospital Payment Fee Schedule that was discussed at the last Consortium meeting.

2. Follow-up FFS Physicians Fee Schedule Update 4/1/04 (Sara Harper)

The FFS Physicians Fee Schedule has been delayed until 5/1/04 due to providers that were significantly impacted. There were a lot of questions regarding the logic of the POS in the pricing and how that works. This information will be available on the FTP server under Reference02 File. We will get details to all of the CEOs by next week.

Action Item: Sara Harper
Details to CEOs.

Q: The rates are going to be effective 5/1/04?

A: Yes.

3. Follow-up Outpatient Hospital Payment Fee Schedule (Sara Harper)

A survey regarding the Outpatient Hospital Payment Fee Schedule went out, but we have not heard back from all of you. Please get that information back to us as soon as possible. We also need the names of those individuals that will be participating in the workgroup. We were thinking that we could possibly schedule the workgroup meetings either before the Consortium meetings or after them. We thought it would be easier to do it this way since you are all ready going to be here for the Consortium meeting. Are there any opinions on this possibility?

Consensus from the health plans was to schedule the workgroup meetings the same day as the Consortium meetings.

We will be getting information out to the contact people once they have been identified. We are still also shooting for the first meeting on 4/21/04.

Q: The 2004 fee schedule, when is it going to be available?

A: Brent Ratterree – It is a month-end processing cycle so it is usually available by the 1st.

Q: Regarding the workgroup. Is that discussion going to be real technical?

A: Both technical and non-technical aspects will be covered.

Lori Petre - If you did not see the survey, please let me know. We will also try to take minutes from the workgroup meeting so that everyone will know what is going on.

4. Standard Follow-up Items

Daily Co-Pays (Dennis Koch/Lori Petre)

Testing of daily co-pays started yesterday, 3/31/04, and they were placed in the FTP folders. If you check your packet, there is an example spreadsheet that Michelle Dillon put together to give you an idea of how the information will be tracked for each health plan. Also, there is a detailed test case spreadsheet (one for each health plan) for you to pick up on your way out.

BBA Data Certification (Dennis Koch)

We would like to apologize for the confusion and the delay in the testing of the BBA data certification process. We have been experiencing some problems that resulted in the temporary suspension of the process until we got the problems resolved. We are sorry for any inconvenience these problems have caused.

Q: Can you create a separate folder for those files that are being held pending validation?

A: We put the file in a holding folder until you submit an email. Once the file has been validated, it is sent on to Mercator. You should receive a daily email regarding the files that are being held. If the files are not certified within 10 days, they are removed.

Lori Petre - If you want people to only get the report, and not certified, we can do that. It was agreed internally that we needed to give the health plans enough lead in and testing time so we are going with an effective date of 5/9/04 with the new process.

Q: For those files that were sent last week in proprietary form when there was a problem, should we resubmit?

A: We need to determine if that is necessary, and we will email you to let you know.

Action Item: Lori Petre/Dennis Koch

Email out to health plans to let them know if they should resubmit proprietary files due to problems from last week.

Q: Don't you also get an email back even when you do not submit a file?

A: Yes, those individuals that have been designated will receive an emailed report stating nothing is outstanding.

Q: In the BBA Data Certification handout it states that the body of the email will be the same text as what is currently being faxed to AHCCCS, and it refers us to the Encounter Manual to get the exact verbiage we need to use. There is nothing that I could find. What should we use?

A: Brent Ratterree – The draft Encounter Manual was published at the end of last year, and that is what it is referring to. Health plans and contractors received a copy of this manual. I will take a look at the language of the body of the email and let you know.

Action Item: Brent Ratterree

To take a look at the language of the body of the email as it stands now and inform accordingly.

Q: When do we start using the new verbiage?

A: Late Friday, 4/2/04.

Lori Petre – I did send a reminder email on 3/11/04 asking for the names of those individuals that need to be on the table for the BBA Data Certification testing purposes so that we could build the test tables. Production tables are now up to Brent, and his staff is currently populating those. Another reminder to use the test email address for test only and the production email address for production only.

834/820 Contingencies (Lori Petre)

Any health plan currently operating under a contingency for the 834/820 Transactions, we are trying to close those contingencies effective 5/1/04. Please let us know what we can do to help you meet this deadline.

5. Other (Lori Petre)

Open Issues/Action Items

I have a report of the Open Issues/Action Items that we still show as open. One of those is that we would send out a confirmation email regarding availability of the 834 test files. I am giving you a verbal confirmation today that those 834 test files started running last night. There is another item regarding BCP and that a suggestion be made to have an off-site co-op between all of the health plans. This was originally assigned to Nancy Mischung, but has since been inherited by Dan Lippert; however, I believe that Dennis Koch has some information.

Dennis Koch – It has been determined that DOA does not have an FTP server suitable to conduct any kind of testing in the event of a disaster, but they are looking into different options. I will be bringing this suggestion up to the AHCCCS disaster team at the next meeting.

Q: Would that be a secure FTP server?

A: I am not sure. I would have to check with their networking team.

Action Item: Dennis Koch
To check with networking team.

Brent Ratterree – There is one Action Item here concerning the patient account number not being unique for encounter reporting purposes. It is really the providers account number for that patient, and I do not care if it is unique or not. The other issue is what happens if it is blank, and I was waiting for someone to give me claims where they had blank patient account numbers, and I have not received any examples yet.

Q: What kind of claims examples are you looking for?

A: A hard copy claim or electronic claim where the patient account number is blank.

Brent Ratterree – I have worked with enough provider shops to know that this field has always been populated. Once I get some examples, then I can provide a response to this issue.

Lori Petre – It is your little HCBS kind of providers that typically do not have a patient account. They fill out only the fields that they have to fill out to get their claims through.

Brent Ratterree – If you have got an issue that you do not know how to resolve, just provide us with some examples, and we can help with that.

Upcoming Meetings

The schedule for upcoming meetings is as follows:

April 21, 2004

May 12, 2004

June 2, 2004

June 23, 2004

I did use Art's suggestion when sending out these meeting invitations, and that seemed to work out okay. For those of you who were unable to open the invitations in this format, please let us know as Melonie does have a Word version that she can forward on to you.

I have not scheduled anything beyond 6/23/04. When we get towards the end of May, we can talk a little bit about if every three weeks is still making sense or if we need to change the frequency. I did not want to schedule those out too far. If you have any questions regarding the upcoming meetings or issues with how we did that scheduling, please let us know.

Q: Is your HIPAA website generally kept up to date?

A: Yes. I gave Melonie updates to the website the other day, and they did get posted. We do try to make sure that the information that is out there is timely. If there is something that is

drastically wrong, we try to get that corrected immediately. It should, for the most part, be kept pretty up to date.

Q: Did I get it wrong? I was under the impression that we were going to discuss UPN numbers.

A: I am going to tell you why we are not doing that today so you did not get it wrong. It got shifted from the agenda, and there is a reason for that. This topic is coming up next.

Ideas for Future Meeting Topics

We had talked in the last meeting about starting to solicit some ideas for future meetings, and one of the things that we talked about was having a presentation on the NPI (National Provider Identifier). We tried to arrange for the industry experts on NPI that have been giving these presentations at X12 and all the other conferences to do this presentation for us via conference call. Unfortunately, none of the three of them who could do it were available to do it today. They will be presenting that in our meeting on 4/21/04, and we have put them at the beginning of the agenda. We will be conducting this via a conference call to them. They will present what they normally do, and we will have an opportunity to ask the experts any questions that we have as a result of that. What we will do is send you the NPI presentation prior to that meeting so that you will have an opportunity to look through it and formulate questions.

Q: Can we set it up so that other people can participate without traveling here?

A: We certainly can do that for their portion of the call. We will look at setting that up.

Action Item: MaryKay McDaniel

Get the NPI presentation out to the health plans to give them time to take a look at it.

I have not gotten any other ideas for future meeting topics. Keep in mind that we are looking for those. What we are going to try to do as much as possible is not rely on our limited expertise on some of these new topic areas; we are going to try and work those connections we do have, and have the experts as often as possible present those initially.

6. Encounters 837/277U

Testing Status/Requirements (Lori Petre)

We are continuing to test encounters. Dennis talked about some of the issues that, unfortunately, we have experienced over the last couple of weeks. Applications have given me every assurance over the last couple of days that they are going to be on top of those. We did talk about the necessity for narrowing the turn around time on any action items that come in. If you do have an email sent in to the AHCCCS HIPAA Workgroup, I may refer it or assign it on to the Applications group, and they are going to try and get you a response in no more than three days. The same thing with Problem Reports. If you do initiate something that turns into a Problem Report, we are asking for a three-day turn around. It may not be that they have a solution in three days; they are to get a response of some form back so that we know what is going on to try and tighten those timelines.

If you have not started testing, we encourage you to start testing as soon as you can. It is fine to start with small files, but we would very much like to see some things near full volume. We also encourage you to test some of the more complicated situations because we would rather not just rely on our testing to address those.

Q: Denied claims, is it optional?

A: Brent Ratterree - Denied claims are optional. You do not have to submit them if you do not want to. We encourage you to submit them though, if they may impact your utilization. We use a lot of that information for different projects for all the plans.

Q: Does the 277U encompass it?

A: Brent Ratterree - We are producing the 277U to replace the adjudicated file the we produce now. I would not expect the supplemental file that we have and the 277U to completely and adequately address your needs. There are some additional data elements that we currently produce that our 277U does not have. There are a few contractors in here that want that information. We are producing a supplemental file to that so they can have that information.

Lori Petre – The information provided on the supplemental file is not exactly the same as on the proprietary file. It cannot duplicate those things that do exist on the 277U.

Q: Since we are in the testing phase of the 837 now, how soon can you take a production file on your side?

A: That will be answered in this next discussion.

As follow-up to a request from Mercy Care, it was determined that a database refresh could be done, but it would have to be done for all health plans. The consensus of the health plans was to have the encounters database refreshed so that they could all start fresh. This refresh will also clear all information previously contained in outbound folders related to encounter test files. Lori will email the health plans to let them know when the refresh will take place.

Action Item: Lori Petre

Email health plans to let them know when the refresh will take place.

Q: If you submit a file, and you find problems with the file, and say you fix it and resubmit it. How is that going to be handled?

A: Brent Ratterree - If the file comes in and passes the front-end syntax, and there is a problem with the file, you are going to get a lot of pends. The only way to get rid of them is to withdraw them.

Health Plan – The problem with that though is if the error is on AHCCCS' side, like a translator issue on the AHCCCS side, that is not possible for the health plan to correct those.

Brent Ratterree – If it is a translator issue, then it will not pend.

Lori Petre – On Brian's example they did. A date was formatted badly on ICD9 surgical codes, and it failed and pended because of what Mercator had translated incorrectly. Brian cannot fix it as he sent it in correctly in the first place. That is a real life example of where that happened to him. ISD would have to facilitate a correction of the data if this were to occur in production.

Q: Where are the modifiers checked?

A: In the mainframe.

Q: If we send a file, and we do not see a 997 or 824, report it?

A: Dennis Koch – Once you receive a certification email stating the file has been received, within an hour or so you should get a response back. If you don't see this, please let us know right away.

As far as the schedule, Dennis and I are meeting with Brent at least once a week, this week we met twice, to confirm where we are with things. As of this morning, we are prepared to implement the encounter transactions, the 837 and 277U, after the April processing is complete. We can begin taking your files two days after the last day you can send in for April. We just won't sweep them until we confirm that the programs are up. I will be sending out a calendar so that you will know when to start looking for acknowledgements, when mainframe processes begin running, etc. There is a conversion that we have to run so there is some timing associated with that. The calendar is going to Dennis, Mike and Brent today, to confirm what we talked through. They will take a look at it, and let me know if they agree with it. I will send it out to all of you as a draft to

make sure you do not have any problems or concerns with the calendar. I will reflect those dates in the Milestones chart as well. We are going to be looking at this approximately twice a week with Brent to see if he has any concerns. We will share any concerns that Brent may have with you. For BHS and CRS, where you have files out there waiting, we will start picking those up according to those calendars. For the others, when you submit. The other thing that I reflected in the Milestones are those things where Brent was talking about beginning to reflect the contingency windows, and the rule of if your dates of service are prior to 7/1, it can be in the old formats, but everything 7/1 and after, has to be in an 837 format. Those are reflected in these now. I think we had a couple of questions just confirming that, and Brent has been responding to those. I will try to get the calendar out to the health plans as soon as possible.

Action Item: Lori Petre

Email health plans draft encounter calendar with pertinent information.

Contingency Planning (Lori Petre)

Because we are looking at implementation, it is time to start thinking about contingencies. What I have to ask is any health plan that won't be ready to go live with 837 Encounters for the May cycle, I will need a contingency plan from you. We are following pretty much the same format that we used for the 834/820, and the same bullet point things I need to know. That is included in your package. I will also email this out so that you will have an electronic form. Do start getting those sent in. I will need to start monitoring those for CMS.

Action Item: Lori Petre

Email health plans contingency plan.

Health Plan – The contingency form still reflects the old date of 3/8/04.

I will put in the new date of 4/11/04 or right around there. I will correct that before I send out the electronic version. We will support on going contingency testing through September; we will just need to have your contingency plan.

Questions/Issues (MaryKay McDaniel)

You have a sheet in your handouts of required health plan IDs in the 837 Encounters. That is what a health plan ID number needs to look like on an encounter. It cannot be a tax ID, it cannot be the six position AHCCCS ID, it cannot be any derivative of the six position AHCCCS ID, it cannot be a derivative of the six position AHCCCS ID with the input mode. It has to be the six position AHCCCS ID number, the TSN, and the input mode in three separate places on the transaction. It cannot be only at the 1000 level. If you do not put it in the 2320 Loop, and at the 2430 Loop in the SVD01, for those of you who's encounters have been going through without doing this, you are going to be sadly disappointed the next file that comes in. I found the glitch that was allowing that to work, and it was a problem with how we were reading. It has been fixed. They will deny for no health plan paid amount. On provider ID's, you do need the six-digit AHCCCS ID number plus the two-digit locator code. That makes it a total of 8 positions. I am seeing some denying for no locator codes or invalid locator codes.

Q: I'm sorry, what were you referring to there?

A: Brent Ratterree –The secondary identifier of the Provider ID; not the primary identifier.

Q: On the locator code, is there editing against that?

A: Brent Ratterree – It is the current editing that is in process now.

Q: Are you verifying the locator code and the tax ID?

A: MaryKay McDaniel - The only tax ID that we are currently looking at and that we are pulling in right now is the billing provide tax ID.

One other thing for those claims folks who are looking for new and fun things to do. There is a change request out for Medicare; it is Change Request 3031. Medicare is now defining inpatient and outpatient bill types, and there were some surprises for some people on that. I would look at that.

7. Encounters NCPDP (Brent Ratterree)

You all should have received a copy of the letter that went to the CEO's over the pharmacy transaction as well as the dates for cutting off the proprietary formats. There was also a very rough draft of the NCPDP 3.2 Layout sent out to all health plans. There were some things missing from that very rough draft that is currently undergoing revision. You will have a new draft that will have a little more information in it such as whether it is required or not, what the Implementation Guide says, and so forth. It will also talk about some positionings within the file, expected data fields for some of that information. It won't exactly repeat what is in the Implementation Guide, but it will give you enough information that you can determine what would be expected from that field. Any of those drug transactions that are real time, you have to wrap them up in a batch transmission mode.

Q: What is the timing on the new draft?

A: Lori Petre – I just got it this morning, and I need to review it with Brent. Depending upon how well they hit what Brent was looking for, and whether or not we have to bounce it back to them, it could be tomorrow or Monday at the latest.

Action Item: Lori Petre

Email the NCPDP 3.2 Draft Layout to the health plans.

Q: The NCPDP 3.2, where are the Medicare codes?

A: They did not address that in the draft that went out, but you will see that in the revised draft. In the health plan payment section you will have the primary payer and the secondary payer if necessary. If Medicare is involved, in most cases they will be the primary payer, when the drug coverage this is formalized. Until then, they are not paying drugs.

Q: The three fields that we normally send in, will they be allowed now?

A: I don't think you will see the same type of information you normally see for Medicare, like deductible, co-insurance, that that type of thing, on pharmacy transactions. Probably, what you will see is an allowed amount, any co-pay amount, and then a payment amount. That is what I expect to see. It may change once they start processing drugs, but at this point, that is all we expect.

Q: In the NCPDP 5.1 there is not metric quantity in it, but in 3.2 there is metric quantity. Can we make metric quantity optional?

A: That will be addressed in the revised 3.2. What I tried to do was to make this modified 3.2 as consistent as possible with the 51 so that when you are capturing that 5.1 data, you can easily translate it into this other format.

Q: Is the AHCCCS ID for the prescriber going to be on the file?

A: What you are submitting to us now as the prescriber provider ID, you will submit that same ID to us in this format.

There were a couple of questions were emailed to Lori that we will discuss now.

Q: Will AHCCCS be converting the inbound NCPDP 3.2 encounters into the proprietary format so that they can load it into the existing encounter process?

A: No, the load process is changing. It is completely different from what it is now. The pended encounter process remains the same, but all the new day stuff is completely different.

If you have had a chance to examine the encounter manual that has been out there for a while, much of that is different. For those of you who have been wondering where the final is on the encounter manual. The final has been waiting on rolling out the details and getting rid of the bumps in the test process before it is issue. There are some examples within the current encounter manual that we are rolling into the companion guide.

Q: Why the decision to choose the NCPDP 3.2 for batch processing when the guide clearly states that it is intended for real time transactions only?

A: We are setting it up for batch because we are wrapping the batch transaction around the 3.2. That is why it looks like a batch transaction.

Q: Health Plan - Why the decision to use 3.2 versus the 5.1?

A: It had to do with a number of reasons. One of which was we had to get certain data elements in as soon as possible, and if we were to push the 5.1, we may not be able to collect that information as quickly as we could going to an older transaction that was all ready out there. As an intermediate step, we are going to implement 3.2 so that we can collect that information that we need.

Q: Health Plan - How long will the 3.2 be used?

A: I don't really have an answer to that question at this time. I would suspect it will be there for a while.

Lori Petre – In our discussion, ISD said we could not even begin looking at moving to another version before October or November at the very earliest, and that is only looking at. All our resources are committed to the end of the year.

Q: Health Plan - So what I am hearing is that you will not be looking to change the version until possibly 2005 if then?

A: I think you are relatively safe in saying that. I cannot give you a promise, because things do happen. There are certain things beyond my control. I would think that it would be stable for at least six months because they are going to be reviewing the data after we have been collecting it for six months. That means, more than likely, it will be stable more than six months.

Q: Health Plan - I am just interested to find out how people are working all NCPDP transactions with their PBMs. What is the strategy? Are you taking the current proprietary file and making sure that has all of the AHCCCS required files, adjudicating all of those in your system, and then pulling out an NCPDP? Or are you trying to force them to do NCPDP?

A: Health Plan – Yes, and to be honest, it all depends on what file format the client is requesting.

Q: Health Plan – Are you charging the client for the development and functionality?

A: Health Plan – Yes. It is a contractual issue. Not every PBM is contracted that way.

Q: It appears that AHCCCS is taking two standards and combining them into one.

A: Yes, it is the batch transaction wrapped around the 3.2.

Lori Petre – If you have additional questions as you are reviewing the 3.2, please submit them to the AHCCCS HIPAA Workgroup, and we will make sure that we get responses out and share them with everyone.

8. Wrap-Up (Lori Petre)

Next meeting is on April 21, 2004, regular time and same place. Make sure you pick up your co-pay testing sheet for your health plan on your way out.

Meeting adjourned.